

**Electronic Billing**  
**Washington State Department of Labor and Industries**  
**HCFA Format**

**Updated July 26, 2004**  
(Electronic Version)

## Index

Introduction .....	3
Getting Started .....	5
Contact Information .....	6
Connectivity with L&I .....	8
Testing Overview .....	10
Getting Setup in Provider Express Billing .....	11
Electronic Format Specifications .....	14
Sample.....	32
L&I Specific Format Instructions .....	33
Bill Types, Type of Service and Place of Service Codes.....	40
Special Instructions for Electronic Billing.....	43
Receiving the Electronic Remittance Advice .....	45
Electronic Remittance Advice Format Specifications .....	46
Electronic Remittance Advice Power of Attorney.....	51
Instructions for Completing the Electronic Billing Authorization .....	52
Electronic Billing Authorization.....	54

## **Introduction**

Electronic billing is available to all providers of service to workers injured while employed by companies insured by the State of Washington (workers' compensation).

There are two accepted format structures for billing, the L&I proprietary and the Federal HIPAA Compliant EDI transaction formats. This booklet will detail the proprietary format structure and provide information regarding conducting e-commerce with the department via the new secure Provider Express Billing web site (PEB). PEB is one of the Department's initiatives to comply with HIPAA and industry standards for electronic data interchange (EDI). This web site is provided as the conduit for your billing, no matter which format structure you use. Your clearinghouse, software vendor and our L&I Electronic Billing Unit are available to answer questions and assist you in your PEB billing. To view PEB go to: <https://fortress.wa.gov/lni/providerbilling/>.

Workers' Compensation programs are legally exempt from HIPAA requirements. Regardless of this exemption, the Department has chosen to adopt the new transaction and security standards in order to be as consistent as possible with other payers and the provider community. In order to accommodate our varied provider community, the Department will accept both HIPAA compliant and current L&I proprietary formats. In addition, the Department will continue to accept bills on paper.

Whichever format structure you use, you may either batch your bills and send them directly to L&I, which may require customized programming on your system, or use a clearinghouse/intermediary to send your bills to us. We do not supply software for this purpose.

If you are interested in pharmacy billing, we support a Point of Sale system that allows you to enter your bills in real-time and get an accepted/rejected notification immediately. For more information on this system, please call our Provider Hotline at 1.800.848.0811.

For more information, please see our web site at

<http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/Billing/Electronic/Learn/default.asp>

### **Paper Bill Processing**

Paper bills received by L&I are screened for basic required information. Acceptable bills are batched by bill type, microfilmed, assigned an internal control number and then placed on a shelf in the order received.

Approximately 70 percent of all paper bills are either paid or denied upon entry. Suspended bills are held in the system pending final adjudication. These are usually processed to a final status within three to five weeks.

The payment cycle cutoff schedule is every two weeks with a cutoff every other Friday. Information regarding bills entered by our data entry staff by 4:30 p.m. on Friday appears on your remittance advice mailed the following week.

To view the cut off and warrant schedule, go to

<http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/PayDates/default.asp> .

## **Processing Electronic Bills**

The success of electronic billing at Labor and Industries has increased the efficiency of bill processing and helped the department to pay providers in a timelier manner. Currently, over 60 percent of all medical bills are received by electronic means.

Bills submitted by electronic media allow you to control when your bills are processed. Bill data received prior to 6:00 p.m., Monday through Friday, will appear in MIPS the following business day at 7:00 a.m.

Generally, a greater percentage of electronic bills are paid or denied upon entry into MIPS than those submitted on paper. MIPS is able to auto-process many of the bills due to fewer errors. We recommend you establish a submission schedule and submit bill files early in the payment cycle to allow time for re-submission if there is a problem with your bill data.

Payment cycles for electronic bills are the same as paper bills, except the cutoff is every other Tuesday at 6:00 p.m. instead of Friday. Bills received by Tuesday's cutoff are given priority by the adjudicators to process as many suspended bills as possible before the payment cycle runs.

Information regarding these bills will appear on the remittance advice mailed the following week with most bills processed to a paid or denied status. This does not mean that payment will be made on all bills. Electronic bills must pass the same Medical Aid Rules' requirements as paper bills. While you may not always receive payment, in most cases you will have a more timely answer to address non-payment.

## **Benefits of Electronic Billing and PEB**

- **Improved efficiency, effectiveness, and profitability of administrative processes.**
- **Decreased administrative costs of healthcare.**
- **Reduced bill-processing time thereby increasing the speed of reimbursement.**
- **Provides access to retrieve your remittance advices from the web.**
- **Billings and electronic remittances are securely transmitted.**
- **Provides links to other L&I information.**
- **Provides immediate confirmation of successfully submitted transmissions.**

## Getting Started

### Provider Requirements

Providers will need to meet the following requirements in order to begin submitting electronic billing files to the Department of Labor and Industries (L&I). These files will all be submitted through the Department's Provider Express Billing (PEB) web site. Please contact the Department's Electronic Billing Unit at 360-902-6511 for assistance with meeting these requirements.

- L&I provider account number.
- Completed Electronic Billing Authorization form for bill submission and/or remittance advice retrieval.
- PEB registration and enrollment for submitting transactions and/or retrieving remittance advices.
- Test file submission, until approved for production submission.

### Clearinghouse Requirements

Third party intermediaries, or clearinghouses, need to meet the following requirements in order to submit workers' compensation billings to L&I on behalf of healthcare providers. Please contact the Department's Electronic Billing Unit at 360-902-6511 for assistance with meeting these requirements.

- Active L&I submitter number for submission and/or remittance advice retrieval.
- PEB registration and enrollment.
- Test file submission, until approved for production submission.

### Reporting Requirements

Washington State law requires you to submit health information to the department or self-insurer when it is required or requested. Washington State has specific laws that require medical providers to disclose health information to the department or self-insured employer for workers' compensation. Billing electronically does not alter the existing reporting requirements for Labor and Industries. **Do not submit reports to the Electronic Billing Unit.** Providers should mail reports separately from the billing transmissions to the following address:

Department of Labor and Industries  
PO Box 44291  
Olympia WA 98504-4291

## Contact Information

### Technical Support

**L&I Electronic Billing Unit** 360-902-6511 or email: [ebulni@lni.wa.gov](mailto:ebulni@lni.wa.gov)

Available Monday – Friday, 8:00 a.m. – 5:00 p.m.

- Provide customer support for Provider Express Billing web site (PEB).
- Assist with troubleshooting electronic billing errors.
- Arrange testing for new providers and submitters.

### Your Clearinghouse or Software Vendor

- Provide assistance with your software program, i.e., using specific features or screens; troubleshooting software errors.
- Provides clearinghouse requirements for submitting provider bill data to L&I.

### Billing Customer Service

**Provider Hot Line** 1-800-848-0811

Available Monday – Friday, 8:00 a.m. – 5:00 p.m.

- Authorize routine services for a claim.
- Verify whether specific services or procedures have been authorized.
- Answer general questions about billing procedures and claim status.
- Explain EOB codes, why bills denied, or are pending.
- Verify number of bills “in process”.
- Verify warrant amounts.
- Verify an inpatient or outpatient authorization number.
- Send a priority message to claims staff or bill payment staff, when additional research or authorization is needed.

### IVR – Interactive Voice Response 1-800-831-5227 (Claim related detail)

Available Monday – Friday, 6:00 a.m. – 7:00 p.m.

Available information is:

- Claim numbers.
- Diagnoses.
- Procedures.
- Drug restrictions.
- Basic status information.

What you need:

- Touch-tone telephone.
- Your provider number.
- Claim number or patient’s social security number.
- Date of injury.

- Additional information is available regarding this automated service by calling the Provider Hot Line.

**Qualis Health (Inpatient and Outpatient Authorizations)**

1-800-541-2894

1-206-366-3360 local number

1-877-665-0383 toll-free fax

Available 7:00 a.m. – 5:00 p.m. Pacific Time

You must request authorization at least five days prior to elective admissions and procedures, and within 24 hours after emergent admissions or procedures. Providers can also leave a phone or fax message requesting a review anytime during non-business hours and weekends. For more information about this program, see Provider Bulletin 02-04.

**Provider Information**

**Washington State Dept. of Labor and Industries web site:** <http://www.lni.wa.gov/>

**Health Services Analysis web site:** <http://www.lni.wa.gov/ClaimsInsurance/> . This site will enable you to access provider information such as Provider Bulletins and Updates, Medical Aid Rules and Fee Schedules, Warrant Schedule, etc.

## **Connectivity with L&I**

### **Provider Express Billing (PEB)**

PEB is an Internet-based system that providers may use to send electronic billing files and/or retrieve remittance advices. PEB will accept the Department's proprietary electronic billing formats and the HIPAA compliant EDI ASC X12N formats. PEB ensures that the transmission of all electronic billing files and remittance advices are secure.

#### **Minimum System Requirements**

##### **➤ Operating Systems**

- Windows 98
- Windows NT
- Windows 2000
- Windows ME
- Windows XP

##### **➤ Browsers**

- Internet Explorer 5.5 or higher

### **Registration / Enrollment / Activation or Authorization**

Once your L&I Provider Account Number is authorized to bill electronically and/or retrieve electronic remittances, you will need to:

- Register with PEB using a logon ID and password.
- Enroll your provider account number in PEB.
- If you enrolled as a primary user, you will receive a letter in the mail with your activation code and you will need to 'Activate' your enrollment,

**OR**

- If you enrolled as a secondary user, your organization's primary user will need to approve your access request.

You will then be able to submit electronic billing files or retrieve remittance advices.

Please go to Customer Support at <https://fortress.wa.gov/lni/providerbilling/> for more detailed instructions.

### **Transmission**

PEB is available 7 days a week, 24 hours a day, except for scheduled maintenance between 4:00 a.m. - 8:00 a.m. on Sundays. Once you are logged into PEB and have access to a provider number, you can submit a billing file by selecting "Submit Bills" or retrieve remittances and other EDI responses by selecting "Retrieve Remittances" at the Provider Express Billing Menu. You will receive immediate confirmation of successfully submitted transmissions. For EDI transactions, PEB provides additional HIPAA compliant acknowledgements.



## **Managing Users for PEB**

Each organization must have at least one primary user to manage access to PEB for users within their organization. The first user who enrolls a provider or intermediary number for PEB automatically becomes the primary user for that provider/intermediary number. Additional primary users may be added.

Primary users are responsible for the management and removal of access for users within their organization. In addition to being able to update/view their own user information, primary users have additional functions available under 'Manage User Information'.

## Testing Overview with L&I

**Contact the Electronic Billing Unit at (360) 902-6511 or [ebulni@lni.wa.gov](mailto:ebulni@lni.wa.gov) prior to submitting test transactions.**

They will:

- Work with L&I's Provider Accounts section to ensure your L&I provider account number is updated for testing.
- Answer questions regarding L&I acceptance of test submissions.
- Provide results of test submissions, i.e., specific errors and/or successful tests.
- After successful testing, have Provider Accounts update the L&I provider account for authorization of production billing.

Whichever method you choose to submit your electronic bills, we will work with you and your programmer to resolve any bill format problems during testing. This will ensure your bills will process smoothly through our Medical Information Payment System (MIPS). Once you are logged into PEB and have access to a provider number, you can submit a test file by selecting "Submit Bills" and check the "This is a test file" box.

The first submission should be a test file of no more than five to ten bills. Included in the file format specifications is a sample printout of the proprietary file format for submission to the Department. **To save time in the test process, please check the output of your program against the sample before submitting a test file.**

## Getting Setup in Provider Express Billing,

### Registration

- Go to <https://fortress.wa.gov/lni/providerbilling>
- Click on the “Register Now” button.
- Click on the “Logon ID and Password” security option.
- Fill in the registration information and click on the “Register” button.
- You will receive a confirmation that your logon ID and password registration has been received and will now take up to 30 minutes to process.

### Enrollment (Primary User; first user who enrolls provider number)

- After you receive the e-mail that your logon ID and password have been accepted (within 30 minutes), go to <https://wvs2.wa.gov/login/lni/providerbilling>.
  - **Note: If the logon ID and password are not accepted, you will need to do the registration process again and choose a different logon ID and password.**
- Enter your logon ID and password in the pop-up box and click on “Ok”.
- Click on “Enroll Provider Number”.
- Enter the provider number you are enrolling and click on the “Submit” button.
- Review provider information.
- Click on the “Enroll” button.
- Review “Primary User Agreement”.
- Click on the “Agree” button.
- Enrollment Confirmation page appears.
- You have the option to enroll another provider number. If you wish to do so click the “YES” button.
- If not, click the “NO” button, which will return you to the Provider Express Billing Menu,  
**OR**
- You can click the Logoff button.

**WAIT UNTIL YOU RECEIVE A LETTER IN THE U.S. MAIL WITH YOUR ACTIVATION CODE.**

### Activation

- Go to <https://wvs2.wa.gov/login/lni/providerbilling>
- Enter your logon ID and password in the pop-up box and click on “Ok”.
- Click on “Activate Provider Number”.
- Select provider number you wish to activate.
- Enter the activation code (from the letter received in the mail).
- Click on the “Activate” button.
- You will receive confirmation that the provider number was successfully activated.

You are now ready to begin submitting billing files and/or retrieving remittances.

## Secondary User Enrollment

- Follow the steps for registration and enrollment up to and including “Enter the provider number you are enrolling” and click the “Submit” button.
- Note that the Review Provider Information page now has two options as far as users are concerned. Because this provider number has already been enrolled and has an activated primary user, subsequent users have the option to be a primary or secondary user. In this example, you are choosing to be a secondary user.
- Review provider information and click “Secondary User” button.
- Read the Provider Express Billing User Agreement.
- Click “Agree” button.
- Enrollment Confirmation page appears.
- You have the option to enroll another provider number. If you wish to do so, click on the “Yes” button.
- If you click the “No” button you will return to the Provider Express Billing Menu,  
**OR**
- You can click the Logoff button.

**Note: You will not receive an activation letter if you enroll as a Secondary User.**

You will need to complete the Electronic Billing Authorization prior to submitting bills. You can find this form, as well as other important information, at

<http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/Billing/Electronic/Learn/default.asp>

## **Implementation Checklist**

### **Provider Responsibilities:**

- ☐ Ensure L&I provider account number is established.
- ☐ Send Electronic Billing Authorization form to Electronic Billing Unit. Include completed Power of Attorney if designating clearinghouse to receive your remittance advice.
- ☐ Complete Provider Express Billing (PEB) registration, enrollment and activation processes.
- ☐ Contact Electronic Billing Unit (EBU) to initialize testing.
- ☐ Send test billing file through PEB.

### **Labor and Industries Responsibilities:**

- ☐ Notification of test file results to provider or submitter.
  - ☐ Updating the provider account number for production bill files.
  - ☐ Notification of authorization for production file transmission.
-

### Format for Electronic HCFA-1500 Claims

**Record Name: Submission Header Record**

**Record Type: AA**

**Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (AA)	9	10	X(2)	
6	Process Date (MMDDYY)	11	16	X(6)	Date the submission was created.
7	Filler	17	80	X(64)	

**Notes:**

- ◆ Must be first record submitted.
- ◆ Must be followed by RT BB.

**Reminders for using these specifications in programming:**

- ◆ All **bolded** fields are required fields. Please see pages 33-39 for L&I specific requirements.
- ◆ All **“X” fields** on all records must be **left justified and space filled**.
- ◆ All **“9” fields** on all records must be **right justified and zero filled**.
- ◆ All records are 80 characters (bytes) only in length. A line delimiter must be used to indicate that the end of the record has been reached (usually a carriage return and line feed in positions 81 and 82). All files must be closed properly with the appropriate end of file delimiter (usually 1A in hex ASCII).
- ◆ Data must be in all upper case (CAPS).
- ◆ The coding must be ASCII.
- ◆ Files are to be named with your provider number and the Julian-date extension (DDD) on which the file was created. Example: 12345.257

### Format for Electronic HCFA-1500 Claims

**Record Name: Batch Header Record**

**Record Type: BB**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (BB)	9	10	X(2)	
6	Insurance Program	11	11	X(1)	1=Medicaid 3=L&I
7	Claim Type (Bill Type)	12	12	X(1)	1=Physician/Practitioner 2=Medical Vendor/Equip. 3=Miscellaneous/Voc. 4=Dental
8	Submitter ID	13	22	X(10)	Number assigned by the insurance program.
9	Filler	23	80	X(58)	

**Notes:**

- ◆ This record starts a batch.
- ◆ Must follow RT AA or XX.
- ◆ Must be followed by RT C1.
- ◆ The C1 record will start a claim and the T2 record will end a claim.
- ◆ This record must be submitted for each insurance program, submitter ID and/or claim type combination.
- ◆ Batches must be sorted by insurance program within the submission.

# Format for Electronic HCFA-1500 Claims

**Record Name: Claim Header 1**

**Record Type: C1**

**Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (C1)	9	10	X(2)	1=Medicaid 3=L&I
6	Insurance Program	11	11	X(1)	1=Medicaid 3=L&I
7	Claim Type (Bill Type)	12	12	X(1)	1=Physician/Practitioner 2=Medical Vendor/Equip. 3=Miscellaneous/Voc. 4=Dental
8	Submitter ID	13	22	X(10)	Number assigned by the insurance program.
9	Billing Provider Number	23	32	X(10)	
10	Patient Account Number	33	45	X(13)	
11	Patient First Name	46	55	X(10)	
12	Middle Initial	56	56	X(1)	
13	Last Name	57	69	X(13)	
14	Filler	70	80	X(11)	

## Notes:

- ◆ This record starts a claim.
- ◆ Must follow RT BB or RT T2.
- ◆ Must be followed by RT C2.



**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 2**

**Record Type: C2**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	Record number within the submission.
2	Record Number (0001-9999)	3	6	9(4)	
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (C2)	9	10	X(2)	
6	Patient Address Line 1	11	32	X(22)	
7	Patient Address Line 2	33	54	X(22)	
8	City	55	69	X(15)	
9	State	70	71	X(2)	
10	Zip	72	80	X(9)	

Notes:

- ◆ Must follow RT C1.
- ◆ Must be followed by RT C3.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 3**

**Record Type: C3**

**Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (C3)	9	10	X(2)	1=Medicaid 3=L&I
6	Patient Date of Birth	11	16	X(6)	MMDDYY
7	Patient Sex	17	17	X(1)	M, F or blank
8	Patient Death Ind.	18	18	X(1)	Y or N
9	Insured ID Number	19	32	X(14)	
10	Insured Group Number	33	45	X(13)	L&I Claim Number
11	Patient Signature Ind.	46	46	X(1)	Y or N
12	Patient Relationship to Insured	47	47	X(1)	1=Self 2=Spouse 3=Child 4=Other
13	Insured First Name	48	57	X(10)	
14	Middle Initial	58	58	X(1)	
15	Last Name	59	80	X(22)	

Notes:

- ◆ Must follow RT C2.
- ◆ Must be followed by RT C4.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 4**

**Record Type: C4**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	Record number within the submission.
2	Record Number (0001-9999)	3	6	9(4)	
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (C4)	9	10	X(2)	
6	Insured Address Line 1	11	32	X(22)	
7	Insured Address Line 2	33	54	X(22)	
8	City	55	69	X(15)	
9	State	70	71	X(2)	
10	Zip	72	80	X(9)	

Notes:

- ◆ Must follow RT C3.
- ◆ Must be followed by RT C5.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 5**

**Record Type: C5**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	Record number within the submission.
2	Record Number (0001-9999)	3	6	9(4)	
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (C5)	9	10	X(2)	
6	Work Related Ind.	11	11	X(1)	Y or N
7	Auto Acc. Ind.	12	12	X(1)	Y or N
8	Other Acc. Ind.	13	13	X(1)	Y or N
9	Other Ins. Ind.	14	14	X(1)	Y or N
10	Other Ins. Name	15	36	X(22)	
11	Campus Status	37	37	X(1)	1=Active 2=Retired 3=Deceased
12	Branch of Service	38	41	X(4)	Army, Navy, AF, Res.
13	Date of Illness/Injury	42	47	X(6)	MMDDYY
14	First Consult Date	48	53	X(6)	MMDDYY
15	Emergency Ind.	54	54	X(1)	Y or N
16	Dates of Disability				
	From Date	55	60	X(6)	MMDDYY
	To Date	61	66	X(6)	MMDDYY
17	Filler	67	80	X(14)	

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 5**

**Record Type: C5**

**Record Size: 80**

---

(continued)

Notes:

- ◆ Must follow RT C4.
- ◆ Must be followed by RT C6.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 6**

**Record Type: C6**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (C6)	9	10	X(2)	1=Medicaid 3=L&I
6	Referring Physician Name	11	30	X(20)	
7	Referring Physician Number	31	40	X(10)	Please refer to page 36 for proper use of this field.
8	Facility Name	41	60	X(20)	
9	Facility Number	61	70	X(10)	
10	Filler	71	80		

Notes:

- ◆ Must follow RT C5.
- ◆ Must be followed by RT C7.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 7**

**Record Type: C7**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (C7)	9	10	X(2)	
6	Hospital Admit Date	11	16	X(6)	MMDDYY
7	Hospital Discharge Date	17	22	X(6)	MMDDYY
8	Laboratory Charges	23	29	9(5)V99	
9	EPSDT	30	30	X(1)	Y or N
10	Family Planning	31	31	X(1)	Y or N
11	Prior Authorization Number	32	40	X(9)	
12	Header Diagnosis 1	41	45	X(5)	No decimal included. Not required for vocational or IME providers.
13	Header Diagnosis 2	46	50	X(5)	No decimal included.
14	Header Diagnosis 3	51	55	X(5)	No decimal included.
15	Header Diagnosis 4	56	60	X(5)	No decimal included.
16	Number of Detail Records	61	62	9(2)	i.e. 01, 02

**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Header 7**

**Record Type: C7**

**Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
(continued)					
Control Information					
17	Prior Authorization Number or Vocational Referral ID Number.	63	72	X(10)	Please refer to page 36 for proper use of this field.
18	Filler	73	80	X(8)	

Notes:

- ◆ Must follow RT C6.
- ◆ Must be followed by RT D1.



**Format for Electronic HCFA-1500 Claims**

**Record Name: Claim Detail 1**

**Record Type: D1**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (D1)	9	10	X(2)	1=Medicaid 3=L&I
6	Line Item Number	11	12	9(2)	i.e. 01,02
7	From Date of Service	13	18	X(6)	MMDDYY
8	To Date of Service	19	24	X(6)	MMDDYY
9	Place of Service	25	26	X(2)	Please refer to page 42 for two-digit place of service values.
10	Type of Service	27	28	X(2)	Please refer to pages 40-41 for type of service values.
11	Procedure Code	29	33	X(5)	
12	Procedure Code Modifier 1	34	35	X(2)	
13	Procedure Code Modifier 2	36	37	X(2)	
14	Diagnosis Code	38	42	X(5)	No decimal included. Not required for vocational or IME providers.
15	Quantity	43	45	9(3)	
16	Submitted Charge	46	52	9(5)V99	
17	Side of Body Ind.	53	53	X(1)	L, R, B or blank. Not required for vocational providers.

**Format for Electronic HCFA-1500 Claims****Record Name: Claim Detail 1****Record Type: D1****Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
(continued)					
Control Information					
18	Report Ind.	54	54	X(1)	Y or N
19	Detail Reference	55	60	X(6)	
20	Filler	61	80	X(20)	

**Notes:**

- ◆ May be preceded by RT C7 or D1/D2 combination.
- ◆ Must be followed by RT D2.
- ◆ Services should be entered in the sequence they occur.

# Format for Electronic HCFA-1500 Claims

**Record Name: Claim Detail 2**

**Record Type: D2**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (D2)	9	10	X(2)	
6	Line Item Number	11	12	9(2)	i.e. 01, 02
7	Remarks	13	52	X(40)	See page 44 for proper use of the remarks field. You must key an “@” as the first character of your remarks.
8	Filler	53	80	X(28)	

## Notes:

- ◆ Must follow RT D1.
- ◆ Must be followed by RT D1 or T1.

# Format for Electronic HCFA-1500 Claims

**Record Name: Total Record 1**

**Record Type: T1**

**Record Size: 80**

Field Number	Field	Length		Picture	Field Description/Comments
		From	Thru		
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (T1)	9	10	X(2)	1=Medicaid 3=L&I
6	Physician Signature on File	11	11	X(1)	Y or N
7	Date Signed	12	17	X(6)	MMDDYY
8	Assigned Ind.	18	18	X(1)	Y or N
9	SSN Number	19	27	X(9)	
10	Employer ID Number	28	37	X(10)	
11	Performing Provider Number	38	47	X(10)	
12	Filler	48	80	X(33)	

## Notes:

- ◆ Must follow RT D2.
- ◆ Must be followed by RT T2.

# Format for Electronic HCFA-1500 Claims

**Record Name: Total Record 2**

**Record Type: T2**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	
5	Record ID (T2)	9	10	X(2)	1=Medicaid 3=L&I
6	Total Charges	11	17	9(5)V99	Total of all line item charges.
7	Patient Liability	18	24	9(5)V99	
8	Other Insurance Paid	25	31	9(5)V99	
9	Balance Due	32	38	9(5)V99	
10	Filler	39	80	X(42)	

## Notes:

- ◆ This record ends a claim.
- ◆ Must follow RT T1.
- ◆ May be followed by RT C1 or RT XX.

**Format for Electronic HCFA-1500 Claims**

**Record Name: Batch Trailer Record**

**Record Type: XX**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	
2	Record Number (0001-9999)	3	6	9(4)	Record number within the submission.
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	1=Medicaid 3=L&I
5	Record ID (XX)	9	10	X(2)	
6	Total Number of Claims Submitted for Batch	11	16	9(6)	Count of C1 through T2 record sequences.
7	Total Number of Records for Batch	17	22	9(6)	
8	Filler	23	80	X(58)	

**Notes:**

- ◆ This record ends a batch.
- ◆ Must follow RT T2.
- ◆ May be followed by RT BB or RT ZZ.

# Format for Electronic HCFA-1500 Claims

**Record Name: Submission Ender Record**

**Record Type: ZZ**

**Record Size: 80**

Field Number	Field	Length From    Thru		Picture	Field Description/Comments
Control Information					
1	Identifier @@	1	2	X(2)	Record number within the submission.
2	Record Number (0001-9999)	3	6	9(4)	
3	Filler	7	7	X(1)	
4	Insurance Program	8	8	X(1)	Blank on this record.
5	Record ID (ZZ)	9	10	X(2)	
6	Filler	11	80	X(70)	

## Notes:

- ◆ Must be last record submitted.

## Sample HCFA File Format

```
@@0001  AA080195
@@0002  3BB31SUBMIT#
@@0003  3C131SUBMIT#      PROVNUM      PTACCOUNTNUM      PATIENTLASTNA
@@0004  3C2
@@0005  3C3              CLAIM#
@@0006  3C4
@@0007  3C5              DATINJ
@@0008  3C6              REFPHY#
@@0009  3C7              HDXCD              01PA/REFID
@@0010  3D101FRMDOSTO-DOSPST  PROCDMD  DXCOD0010001234SR
@@0011  3D201@REMARKS FIELD - 40 CHARACTERS .....
@@0012  3T1              PERFPR#
@@0013  3T20001234
@@0014  3XX000001000013
@@0015  ZZ
```



**L&I Specific HCFA-1500 Format Instructions**  
(Includes Statement for Miscellaneous Services)

Providers who submit bills on either the HCFA or Miscellaneous bill forms may use the HCFA-1500 specifications.

The following are the Record Types and Required Fields for submitting electronic bills to L&I.

Required

Field                      Field Description/Comments

**Record Type AA**

- |   |   |
|---|---|
| 1 |   |
| 2 | Record number within the submission.                |
| 5 |   |
| 6 | Date the submission was created. Use MMDDYY format. |

**Record Type BB**

- |   |  |
|---|--|
| 1 |  |
| 2 | Record number within the submission.   |
| 4 | 3 = L&I  |
| 5 |  |
| 6 | 3 = L&I  |
| 7 | 1 = Physician/Practitioner<br>2 = Medical Vendor/Equipment<br>3 = Miscellaneous/Vocational Rehabilitation<br>4 = Dental  |
| 8 | Use your L&I provider account number. If you are a third party intermediary, use your submitter number assigned by L&I. Valid L&I provider account numbers consist of 2 to 7 digits. Leading zeros are optional. <b>Enter up to 7 digits only.</b> |

RequiredField      Field Description/Comments**Record Type C1**

1	
2	Record number within the submission.
4	3 = L&I
5	
6	3 = L&I
7	1 = Physician/Practitioner 2 = Medical Vendor/Equipment 3 = Miscellaneous/Vocational Rehabilitation 4 = Dental
8	Use the L&I provider account number for the entity who is sending the claims to L&I. If you are using an intermediary/clearinghouse to send your bills for you, this would be their L&I provider number. If you are not using an intermediary/clearinghouse, this would be the group/clinic number (if one) or an individual provider number (if no group/clinic number). Valid L&I provider account numbers consist of 2 to 7 digits. Leading zeros are optional. <b>Enter up to 7 digits only.</b>
9	Use the L&I provider account number of the "pay to" provider. This would be the group/clinic number (if one) or an individual provider number (if no group/clinic number). Valid L&I provider account numbers consist of 2 to 7 digits. Leading zeros are optional. <b>Enter up to 7 digits only.</b>
10	Use your own patient account number. The first 12 characters entered in this field will appear on your L&I remittance advice.

13

**Record Type C2**

1	
2	Record number within the submission.
4	3 = L&I
5	

Required

Field            Field Description/Comments

**Record Type C3**

1	
2	Record number within the submission.
4	3 = L&I
5	
10	Use the 7-digit L&I claim number. Do not enter spaces, dashes (-) or other special characters in the claim number field. Valid L&I claim numbers begin with one or two alpha characters followed by all numerics.

**Record Type C4**

1	
2	Record number within the submission.
4	3 = L&I
5	

**Record Type C5**

1	
2	Record number within the submission.
4	3 = L&I
5	
13	Use MMDDYY format.

**Record Type C6**

1	
2	Record number within the submission.
4	3 = L&I
5	

Required  
Field

Field Description/Comments

- 7 Use the L&I provider account number of the physician or vocational provider who referred the injured worker to you. **For provider type 97, miscellaneous payee**, the vocational provider number is required. Failure to add this information will result in denial of bills. Valid L&I provider account numbers consist of 2 to 7 digits. Leading zeros are optional. **Enter up to 7 digits only.**

**Record Type C7**

- 1
- 2 Record number within the submission.
- 4 3 = L&I
- 5
- 12 Use the appropriate ICD-9-CM diagnosis code **without decimals**. The diagnosis code used here will appear in our bill payment system on all lines where the diagnosis field is left blank (field 14 of the D1 record). **Vocational/IME providers: do not enter data here.**
- 16 The number of D1/D2 record combinations for this bill.
- 17 **Prior Authorization Number:** treatment authorization code assigned by L&I's utilization review firm; required for outpatient services only (please see Provider Bulletin 00-08). **Vocational Referral ID:** effective 6/1/01, vocational providers and those ancillary providers billing codes 0389R or 0390R are required to enter the vocational referral ID number (please see Provider Bulletin 01-03). **Invalid information in this field will cause delays in the processing and payment of your bills.**

**Record Type D1**

- 1
- 2 Record number within the submission.
- 4 3 = L&I
- 5
- 6 Use 01 for the first D1 record of this bill, 02 for the second D1 record of this bill, etc. up to a maximum of fifty D1/D2 record combinations per bill.
- 7 Use MMDDYY format.

Required  
Field

Field Description/Comments

- 8 Use MMDDYY format. The "to date of service" must be entered, even if it is the same as the "from date of service".
- 9 See page 42 to determine the correct "Place of Service" code.
- 10 See pages 40-41 to determine the correct "Type of Service" code for your provider/bill type.
- 11 Use the appropriate procedure code found in the L&I Medical Aid Rules and Maximum Fee Schedules. You can request a copy of the current Fee Schedule by contacting the Department's Provider Accounts section at (360) 902-5140.
- 12 Do not fill this field if there is no applicable modifier. For Dental bills, enter the two-digit tooth number. Valid tooth numbers are 01 through 32. Do not use field 13 for a second modifier or tooth number.
- 14 Use the appropriate ICD-9-CM diagnosis code **without decimals**. If this field is left blank, the diagnosis code entered in field 12 of the C7 record will auto-fill as the line item diagnosis code. **Vocational/IME providers:** do not enter data here.
- 15 Use the number of units or days in whole numbers. **Do not use fractions or decimal points.**
- 16
- 17 Valid side of body indicators are L, R, B (bilateral) or blank. **Vocational providers:** do not enter data here.

**Record Type D2**

- 1
- 2 Record number within the submission.
- 4 3 = L&I
- 5
- 6 Use 01 for the first D2 record of this bill, 02 for the second D2 record of this bill, etc. up to a maximum of fifty D1/D2 record combinations per bill.
- 7 **Caution:** See page 44 for proper use of the Remarks field. Improper use may cause delays in the processing and payment of your bills. **You must key an "@" as the first character of your remarks.**

Required

Field                      Field Description/Comments

**Record Type T1**

1	
2	Record number within the submission.
4	3 = L&I
5	
11	Enter the individual L&I provider account number of the practitioner who provided the service. Valid L&I provider account numbers consist of 2 to 7 digits. Leading zeros are optional. <b>Enter up to 7 digits only.</b>

**Record Type T2**

1	
2	Record number within the submission.
4	3 = L&I
5	
6	Total of all line item charges (field 16 of the D1 records).

**Record Type XX**

1	
2	Record number within the submission.
4	3 = L&I
5	
6	Number of C1 through T2 record sequences in the batch.
7	The total number of records in this batch (BB record through XX record). Do not include the AA or the ZZ records.

<u>Required</u> <u>Field</u>	<u>Field Description/Comments</u>
---------------------------------	-----------------------------------

**Record Type ZZ**

1	
2	Record number within the submission.
5	

## Bill Types, Type of Service and Place of Service Codes

Note: The list below regarding the type and place of service codes is also found in Department billing instructions. It appears here for your convenience only. Please contact the Department's Provider Accounts section at (360) 902-5140 if you need a current copy of the billing instructions.

The following bill types, type of service and place of service codes are to be used by all providers submitting bills for HCFA-1500 or Miscellaneous format.

### Bill Type Options

- |   |   |
|---|---|
| 1 | Physician/Practitioner                  |
| 2 | Equipment/Medical Vendor                |
| 3 | Miscellaneous/Vocational Rehabilitation |
| 4 | Dental                                  |

Provider Type	Bill Type	Type of Service
Ambulance	3	9
Ambulatory Surgery Center	1	3
ARNP/FNP	3	N
Audiologist	3	*(3)
Chiropractor	1	C
Clinic (Chiropractor)	1	C
Clinic (Medical)	1	3
Clinic (Physical Therapy)	1	P
CRNA	3	N
Dentist	4	*(2)
Drug/Alcohol Treatment		
Facilities/Ancillaries	3	9
Physician Services	1	*(4)
DME Supplier	2	9
Free-Standing Emergency Room –	1	3
Physician Services		
Home Health Agency	3	9
Hospital – Professional Services	1	3
Independent Diagnostic Testing Facility	1	3
Infusion Therapy	3	9
Interpreter	3	9
Job Mod./Pre-Job Mod. Consultant	3	9
Laboratory/Blood Bank	1	3
LMT	3	9
Lodging	3	9
Miscellaneous Non-Physician	3	9
Naturopath	1	D
Nurse Case Management	3	9



Nursing Home, etc.	3	9
Nurse Service Agency	3	9
Optician	3	*(3)
Optometrist	3	*(3)
Orthotist	2	9
Osteopath	1	3
OTR	3	9
Pain Clinic	1	9
Pain Clinic Voc Rehab	1	V
Panel Examiner	1	3
Pharmacy – Medical Supplies	2	9
Physical Therapy	1	P
Physician	1	3
Physician Assistant, Certified	1	3
Placement Agency	3	V
Podiatric	1	*(3)
Prosthetist	2	9
Psychologist/ Psychiatrist	1	3
Public Transportation	3	9
Radiology	1	3
Registered Dietician	3	9
Registered Nurse, Biofeedback	3	N
Registered Nurse/NR First Assistant	3	N
Respiratory Therapy	1	P
Retraining - facility, daycare, supplier, consultant	3	V
Speech Therapist	3	*(3)
Vocational – firm, forensic, counselor	3	V

- \*(1) Key Type of Service 3 if billing Physicians' Current Procedural Terminology (CPT™) codes and Type of Service 9 if billing local codes.
- \*(2) Key Type of Service 3 if billing CPT™ or local codes and Type of Service 4 if billing Dental codes (D0100-D9999).
- \*(3) Key Type of Service 3 if billing CPT™ or codes and Type of Service 9 if billing HCPC or Local Codes.
- \*(4) Key Type of Service 3 if billing CPT™ or HCPC codes and Type of Service 9 if billing local codes.

CPT™ is a trademark of the American Medical Association.

## Place of Service Codes

03	School	34	Hospice
04	Homeless Shelter	35	Adult Living Care Facility ( <b>place of service terminated as of 7/1/01</b> )
05	Indian Health Svc. Free-standing Facility	41	Ambulance – Land
06	Indian Health Svc. Provider-based Facility	42	Ambulance – Air or Water
07	Tribal 638 Free-standing Facility	49	Independent Clinic
08	Tribal 638 Provider-based Facility	50	Federally Qualified Health Center
11	Office	51	Inpatient Psychiatric Facility
12	Home	52	Psychiatric Facility Partial Hospitalizations
13	Assisted Living Facility	53	Community Mental Health Facility
14	Group Home	54	Intermediate Care Facility for the Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care Facility	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	57	Non-residential Substance Abuse Treatment Facility
22	Outpatient Hospital	60	Mass Immunization Center
23	Emergency Room	61	Comprehensive Inpatient Rehab. Facility
24	Ambulatory Surgical Center	62	Comprehensive Outpatient Rehab. Facility
25	Birthing Center	65	End-Stage Renal Disease Treatment Facility
26	Military Treatment Facility	71	State of Local Public Health Clinic
31	Skilled Nursing Facility	72	Rural Health Clinic
32	Nursing Facility	81	Independent Laboratory
33	Custodial Care Facility	99	Other Unlisted Facility

## Special Instructions for Electronic Billing

### Reporting Requirements

Electronic billing does not alter the existing reporting requirements for L&I. **All services currently requiring reports continue whether bills are submitted electronically or on paper.** Providers should continue to mail reports separately from the billing to the following address:

Department of Labor and Industries  
PO Box 44291  
Olympia WA 98504-4291

### Backup Documentation for All Bills

The following supporting documentation is required for all HCFA-1500 or Miscellaneous bills:

- ◆ Laboratory and pathology reports
- ◆ X-ray findings
- ◆ Operative reports
- ◆ Office notes
- ◆ Consultation reports
- ◆ Diagnostic study reports
- ◆ 60-day progress reports
- ◆ Independent medical examination reports
- ◆ Cost invoices of supplies furnished

The injured worker's name and claim number must be in the upper right hand corner of each page of documentation.

### Re-bills

Previously denied bills or those that paid at \$0.00 may be re-billed electronically. **Do not** indicate "re-bill" or the ICN of the original bill in the remarks field. It is not necessary to send backup documentation again when re-billing

### Adjustments

Adjustments cannot be billed electronically. If a bill has been paid in error or if you wish reconsideration of the amount paid, you must submit a paper Provider's Request for Adjustment form (F245-183-000).

## Use of the Remarks Field

A message of up to 40 characters may be entered in the Remarks/Detail Narrative Comments field. The electronic HCFA/Misc format allows for one Remarks field per line item. **Improper use of the remarks field can cause unnecessary delay in the payment of your bills.** MIPS will suspend any bill which has data keyed in the Remarks field so that it may be manually adjudicated based upon the remarks. Remarks such as routine descriptions of procedure or diagnosis codes or the results of diagnostic studies should **not** be entered in this field, nor should requests for authorization of services or authorizing authority. **To enter valid remarks (i.e., multiple modifiers) you must key an "@" as the first character of your remarks (e.g., @26, TC).**

## Required Remarks

In some cases, further explanation of services rendered is required in the remarks field. The following situations are examples:

Procedure codes referencing an unlisted service -  
Indicate the nature of the service.

Procedure codes having the following modifiers -  
22 - Explain the nature of the additional charges.  
99 - Indicate all applicable modifiers.

Refractions -  
Indicate whether the old prescription was available. Failure to supply this information may cause your bill to be denied.

Steffee Plate Surgeries -  
Enter the word "Steffee".

Gortex Procedures - Procedure code 27429  
Enter the word "Gortex".

Claimant Reimbursements -  
In cases where the injured worker has paid for pharmacy items or equipment, you may indicate that reimbursement should be sent to the injured worker by entering the words  
"Pay Claimant". Submit claimant reimbursements on separate bill from provider's charges.

## Optional Remarks

Appropriate use of the Remarks field is not limited to those messages indicated above. If you are in question of what may be appropriate, please contact the Electronic Billing Unit at (360) 902-6511 or [ebulni@lni.wa.gov](mailto:ebulni@lni.wa.gov).

## **Receiving the Electronic Remittance Advice**

The Electronic Remittance Advice comes in the format specified in the following section. Your programmer or vendor supporting your electronic billing software may be able to assist you in making use of this option.

When you are ready to begin receiving the Electronic Remittance Advice, simply notify our office at (360) 902-6511 or [ebulni@lni.wa.gov](mailto:ebulni@lni.wa.gov) and we will update your account. If you would like your intermediary to receive your Electronic Remittance Advice, you must sign and notarize the Power of Attorney for this designation. Return it to the following address:

Department of Labor and Industries  
Electronic Billing Unit  
PO Box 44264  
Olympia WA 98504-4264

The Electronic Remittance Advice will be available on our web site on a bi-weekly basis in coordination with the department payment cycle.

All correspondence pertaining to the Electronic Remittance Advice can be sent to the address above.

If you have questions regarding the Electronic Remittance Advice, please call either of the above-mentioned phone numbers.

**Electronic Remittance Advice Record Format  
Medical Header Record**

Field	Position		Picture	Comments
	Start	End		
Record Code	1	2	X(2)	"M1"
Media	3	3	X(1)	3 = Web & Hardcopy
Payee Number	4	10	9(7)	
Remittance Advice Number	11	19	9(9)	
Payment Date	20	25	9(6)	MMDDYY
Provider Number	26	32	9(7)	
Claim Number	33	39	X(7)	
Claimant Name	40	63	X(24)	
Internal Control Number	64	80	9(17)	
Filler	81	160	X(80)	

Notes:

- ◆ First record for each bill.
- ◆ Followed by "M2" record.
- ◆ All "X" fields are left justified.
- ◆ All "9" fields are right justified.
- ◆ All records are 160 bytes.
- ◆ Files will be sent with filenames consisting of your submitter ID with the extension of the Julian date on which the RA was generated. (Note: there may be multiple files.)

**Electronic Remittance Advice Record Format  
Medical Service Record**

Field	Position		Picture	Comments
	Start	End		
Record Code	1	2	X(2)	"M2"
Media	3	3	X(1)	3 = Web & Hardcopy
Payee Number	4	10	9(7)	
Line Number	11	12	X(2)	
First Date of Service	13	18	9(6)	MMDDYY
Last Date of Service	19	24	9(6)	MMDDYY
Type of Service	25	25	X(1)	
Procedure Code	26	30	X(5)	
Procedure Code Modifier	31	32	X(2)	
Procedure Code Modifier	33	34	X(2)	
Procedure Code Modifier	35	36	X(2)	
Procedure Code Modifier	37	38	X(2)	
Units of Service	39	42	9(4)	
Filler	43	43	X(1)	
Line Item Charge	44	50	9(5)V99	
Line Item Allowed	51	57	9(5)V99	
Line Item Non-Cov or Tax	58	64	9(5)V99	
Line Item Payable	65	71	9(5)V99	
Line Item EOB (1)	72	74	X(3)	
Line Item EOB (2)	75	77	X(3)	

**Electronic Remittance Advice Record Format  
Medical Service Record**

Field	Position		Picture	Comments
	Start	End		
(continued)				
Detail Reference Number	78	83	X(6)	
Filler	84	160	X(77)	

Notes:

- ◆ Follows “M1” record.
- ◆ Followed by “M3” record for each bill.



**Electronic Remittance Advice Record Format  
Medical Trailer Record**

Field	Position		Picture	Comments
	Start	End		
Record Code	1	2	X(2)	“M3”
Media	3	3	X(1)	3 = Web & Hardcopy
Payee Number	4	10	9(7)	
Total Charge	11	19	9(7)V99	
Non-Covered Charge	20	28	9(7)V99	
Net Charge	29	37	9(7)V99	
Third Party Payment	38	46	9(7)V99	
Total Payable Amount	47	55	9(7)V99	
Bill EOB Code (1)	56	58	X(3)	
Bill EOB Code (2)	59	61	X(3)	
Status of Bill	62	62	X(1)	P = Paid D = Denied R = Returned I = In Process
Type of Bill	63	63	X(1)	E = Equipment K = Dental M = Miscellaneous N = Nursing P = Practitioner V = Voc Rehab Q = Gross Adjustment
Patient Account Number	64	83	X(20)	
Filler	84	160	X(77)	

Notes:

- ◆ Follows “M2” record for each bill.
- ◆ May be followed by “M1” record for next bill or by “99” record to end file.

**Electronic Remittance Advice Record Format  
Provider Trailer Record**

Field	Position		Picture	Comments
	Start	End		
Record Code	1	2	X(2)	“99”
Media	3	3	X(1)	3 = Web & Hardcopy
Payee Number	4	10	9(7)	
Submitter Number	11	17	9(7)	
Filler	18	160	X(143)	

Notes:

- ◆ Follows “M3” record; ends file.

State of Washington  
County of \_\_\_\_\_

### **Power of Attorney for Electronic Remittance Advice**

KNOW ALL PERSONS BY THESE PRESENT, that the undersigned, \_\_\_\_\_

of \_\_\_\_\_ County, Washington does hereby make, constitute and appoint

\_\_\_\_\_ as attorney in fact for the benefit of the undersigned, and  
(name of intermediary)  
in its name, place and stead for the following purposes:

To act as an agent for the undersigned in receiving the undersigned's Industrial Insurance remittance advice by electronic means from the Washington State Department of Labor and Industries Medical Information and Payment System. The remittance advice information will contain itemized detail of bills processed by the Medical Information and Payment System, including billed charges, allowed charges, payable charges, explanation of denied charges or partial payments, and a listing of those bills still in process as of the close of the processing cycle.

This Power of Attorney is made effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
L&I Provider Number

By: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

## **Instructions for Completing the Electronic Billing Authorization**

**Prior to billing electronically, it will be necessary to execute an Electronic Billing Authorization. If you choose to employ a clearinghouse/intermediary to bill for you, the Billing Authorization includes a section for you to designate the name of the company and provides permission for the clearinghouse/intermediary to bill on your behalf.**

After completing, **please make a copy for your file and mail the original** as instructed by your clearinghouse/intermediary – either return to them or to the Electronic Billing Unit. We will update your provider account and e-mail or call your clearinghouse/intermediary when you are set up in our system. If you are using a clearinghouse/intermediary, you will need to coordinate with them that you are ready to bill electronically.

### **PROVIDER INFORMATION**

#### **Name of Firm or Individual (Provider):**

List the group/clinic name, or individual practitioner name if no group affiliation. Only one Authorization under the business name and tax ID is required to cover the entire group and any future practitioners added to the group. If an individual practitioner incorporates and adds other providers of service to his/her business under a new tax identification number (EIN), a new Billing Authorization will be required.

#### **Address:**

List the provider's billing address.

#### **City, State and Zip:**

List the city, state and zip code of the provider's billing address.

#### **L&I Provider Account Number:**

List the group/clinic (or individual practitioner) provider account number assigned by L&I. This number is used to submit your bills electronically.

#### **Contact Name:**

List the name of the person to contact if we have questions/concerns.

#### **IRS Tax Identification Number:**

List your current taxpayer number (EIN or SSN).

#### **Telephone:**

List the phone number of the provider's billing office.

#### **Effective Date:**

Enter the date you will start sending bills for processing to your clearinghouse/intermediary. (Note: Our billing system accepts only one submitter. You must STOP sending bills to your old clearinghouse/intermediary before submitting to your new clearinghouse/intermediary. Changes to the system usually take 3-5 days after receipt of the Billing Authorization).

## **CLEARINGHOUSE/INTERMEDIARY INFORMATION**

**Clearinghouse/Intermediary Name:**

List the name of the clearinghouse/intermediary you will use.

**Address:**

List the clearinghouse/intermediary business address.

**City, State and Zip:**

List the city, state and zip code of the clearinghouse/intermediary.

**L&I Account Number for Clearinghouse/Intermediary:**

List the L&I provider number of the clearinghouse/intermediary you will use.

**Effective Date:**

Please verify the effective date of the update.

**Contact Name:**

List the name of the person to contact if we have questions/concerns.

**Telephone:**

List the phone number for the clearinghouse/intermediary.

**E-mail:**

List the e-mail of the person to contact for billing setup notifications.

## **AUTHORIZING SIGNATURE**

**Provider Name:**

Please print the group/clinic (or individual practitioner) name.

**Signature and Date:**

The owner or office manager must sign and date the document.

**Signatory Name (Print Name):**

Print the name of the person who signs the document.

If you have any questions regarding the Electronic Billing Authorization, please call (360) 902-6511.

Please return the completed Electronic Billing Authorization to the following address:

Department of Labor and Industries  
Electronic Billing Unit  
P.O. Box 44264  
Olympia, WA 98504-4264

State of Washington  
Department of Labor & Industries  
Health Services Analysis/MIPS  
Electronic Billing Unit  
PO BOX 44264  
Olympia WA 98504-4264



## Electronic Billing Authorization

### **DEFINITIONS:**

***“Provider”*** shall mean an institution, agency, or person who has been issued a provider number with the Department to furnish medical care, goods, and/or services to clients, and is eligible to receive payment from the Department.

***“Clearinghouse/Intermediary”*** shall be the term herein used to describe a third party employed by the L&I provider to submit claims to the Medical Information Payment System (MIPS).

### **PURPOSE**

The purpose of this form is to authorize the Department of Labor & Industries (L&I) to accept electronically submitted bills for services provided to injured workers pursuant to the Industrial Insurance Act from the Provider named in the *Provider Information* Section on page 2:

### **PROVISIONS**

1. **Submission, receipt, processing and payment of electronic billing is completely voluntary.**
2. The Provider may contract with a third party for services to process billings. **Clearinghouse/Intermediary information must be entered in the *Clearinghouse/Intermediary Information* Section on page 2. L&I must be informed prior to any changes being made to this information.**
3. The Provider accepts full responsibility for the accuracy and truthfulness of all bills submitted to L&I for payment on its behalf.
4. The Provider accepts full responsibility for all warrants endorsed or deposited on its behalf. Any payments forwarded to the Provider's third party shall be considered as payment to the Provider. L&I shall not be held further accountable for such payments.
5. The Provider understands that payment from L&I will be from state funds and that any falsification or concealment of a material fact may be prosecuted under state laws.
6. The Provider shall comply with all billing requirements and format specifications that are current at the time of the submission. Failure to comply with these requirements/specifications may result in suspension of this arrangement and/or rejection of submission(s) by L&I. For current information, be sure to check our web site at <http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/Billing/Electronic/Learn/default.asp>.
7. **L&I shall contact the Clearinghouse/Intermediary (or Provider, if sending as an independent) upon completion of this Authorization to initiate electronic billing. To avoid possible billing errors, the Provider is advised not to proceed with electronic billing until instructed to do so by their Clearinghouse/Intermediary.**

**PROVIDER INFORMATION:**

Name of Firm or Individual (Provider)	L&I Provider Account Number
Address	Contact name
Address	IRS TAX IDENTIFICATION NUMBER
City, State, Zip + 4	TELEPHONE

**CLEARINGHOUSE/INTERMEDIARY INFORMATION:**

**Entry of Clearinghouse/Intermediary information below constitutes Provider's authorization for L&I to accept and process billing through the following Clearinghouse/Intermediary.**

Clearinghouse/intermediary Name	L&I Account Number For Clearinghouse/intermediary
Address	Contact name
City, State, Zip + 4	Telephone
	E-mail

**EFFECTIVE DATE:**

Enter the date that you want your bills to be processed through L&I using your requested Clearinghouse/Intermediary. Failure to enter an effective date may cause your bills to suspend or be denied.

Effective Date \_\_\_\_\_

Provider's signature below authorizes L&I to accept and process electronic billing within the provisions listed above.

\_\_\_\_\_  
PROVIDER NAME

\_\_\_\_\_  
SIGNATURE (MUST BE ORIGINAL SIGNATURE)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATORY NAME (PRINT NAME)